Commonwealth of Virginia
Department of Social Services

NEIGHBORHOOD ASSISTANCE PROGRAM

CONTRIBUTION NOTIFICATION FORM B **(CNF-B)**

For Use by Medical Professional Providing Certain Health Care Services
Between July 1, 2004 and June 30, 2005
(SEE BACK FOR INSTRUCTIONS BEFORE COMPLETING)

PART I. TO BE COMPLETED BY MEDICAL PROFESSIONAL DONOR (TYPE or PRINT ONLY)

1. _____
Name of Donating Medical Professional

2. (Dr./Mr./Mrs./Ms.)_____
(Circle One) Contact Person (Full Name)

3. _____
Address

_____
City, State, Zip Code

_____
Telephone Number With Area Code

4. Social Security #_____

5. Type of Medical Professional: _____
(Refer to instructions on back of form)

6. Services donated at: Clinic : _____ Office _____

Other _____
Please specify where donation occurred

7. Date(s) of donated health care services:

from: _____/_____/_____ to: _____/_____/_____
(Actual date of donation / Beginning to ending date)

8. Value of donated services: $_____
(Attached Required Supporting Documentation)

Note: The value of donated services cannot exceed the lesser of the reasonable cost for similar services from other providers or $125 per hour.

NOTE: Determining the effect of making a donation for tax credits on a donor's tax liability is the sole responsibility of the donor. Before making a donation or when tax related questions occur, donors are encouraged to seek advice from their tax accountant or other tax advisor.

PART II CERTIFICATION BY MEDICAL PROFESSIONAL

I certify that the value of the donated service(s) was determined by the standards stated in the instructions and does not exceed the statutory maximum. I also certify I will not receive any type of compensation or reimbursement from medical insurance filing or from my company for the donated service(s) nor will my company receive any compensation. I understand that if I falsify information, I may be subject to penalties prescribed by the Virginia Departments of Taxation and Social Services. Please sign, date, and return this form to the NAP organization for completion. A tax credit certificate will be mailed to you from the Department of Social Services.

_____ _____
Date Signature of Donor Designee

PART III TO BE COMPLETED BY ORGANIZATION (TYPE or PRINT ONLY)

I certify that the above medical professional has made this donation of providing health care services for this approved organization and the listed value of the donation does not exceed the statutory limits. I understand that if I falsify information, I may be subject to penalties prescribed by the Virginia Departments of Taxation and Social Services.

1. _____ 2. Project I.D. #_____
(Organization Name as listed on Approval Certificate) (See Organization Approval Certificate)

3. Organization Address: _____ Phone #_____
(Street, City, State, Zip Code) (Include Area Code)

4. Neighborhood Assistance Organization Approval Year: 07 / 01 / 2004 - 06 / 30 / 2005

_____ _____
Date Signature of Neighborhood Assistance Organization Designee

Revised 7/04

INSTRUCTIONS FOR DONATIONS NOTIFICATION FORM B (CNF-B)

For Use by Medical Professional Providing Certain Health Care Services between July 1, 2004 and June 30, 2005.

General:

- Determining the effect of making a donation for tax credits on a donor's tax liability is the sole responsibility of the donor. Before making a donation, or when tax related questions occur, donors are encouraged to seek advice from their tax accountant or other tax advisor.
- Donations must be made with no strings attached.
- Discounting (partial donations) and bargain sales are not allowable for NAP donations.
- A copy of the Services Contribution Data Sheet or spreadsheet listing the job title of the individual providing the service, type of service provided, date(s) of donation, hourly rate, total hours worked, and total value for services must be submitted with the CNF-B. The Certification by Medical Professional (on the Services Contribution Data Sheet) must be signed by the donor and attached to each spreadsheet. Retain a copy of all documentation in your files. Failure to do so may result in a donor's loss of the tax credit.

Specific Instructions:

PART I

Items 1-3: Name of medical professional who made the donation, name of contact person for the donor, mailing address, and phone number of donor.

Item 4: Social Security number of medical professional.

Item 5: Enter the type of medical professional: **physician, pharmacist, dentist, chiropractor, physician assistant, nurse practitioner, optometrist, dental hygienist, nurse, professional counselor, clinical social worker, clinical psychologist, marriage** and **family therapist** and **physical therapist**, who are licensed pursuant to Title 54.1 and who provide health care services without charge within the scope of their licensure. **Credits are limited to the above mentioned medical professionals.**

Item 6: Check location for donated services. If not at a clinic or doctors office, please specify where services occurred.

Item 7: Enter the actual date or dates over which the health care services were donated. Date(s) of donation must occur within the same program approval year.

Item 8: Enter the value of donation:

As provided in §63.2-2004 C, of the Code of Virginia, the value of such donated services rendered by a physician, pharmacist, dentist, chiropractor, physician assistant, nurse practitioner, optometrist, dental hygienist, nurse, professional counselor, clinical social worker, clinical psychologist, marriage and family therapist and physical therapist shall not exceed the lesser of the reasonable cost for similar services from other providers or $125 per hour. The value to be used for donated health care services must be agreed to by the donor and the NAP organization prior to the services being donated and documentation of the donation must be retained.

PART II Sign and date the certifications. Return the CNF with supporting documentation to the NAP organization.

NOTE: Incomplete and/or illegible Contribution Notification Forms will be returned.

Revised 7/04